Members Health Fund Alliance

Pre-Budget submission 2018-19
15 December 2017

Members Health
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Putting members' health before profit

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EXECUTIVE SUMMARY

A thriving private health sector is critical to the future of world leading healthcare in Australia. The Australian health system consistently performs better than the OECD average and private health is a key component of that success. Around 13.5 million Australians choose to have private health insurance, which provides them with immediate access to high quality and affordable care.

In the 2016-17 financial year alone, insurers paid around $20 billion in benefits to consumers. That is $20 billion that would otherwise be picked up by taxpayers. The private health system provides care for even the most complex of health conditions, covering thousands of procedures including 2 in 3 elective surgeries, more than 45% of chemotherapy treatments, 7 in 10 eye surgeries and nearly half of heart surgeries. That's in contrast to the public system where patients are often forced to endure long waiting lists that in some jurisdictions can extend well beyond a year.

The savings to taxpayers is highlighted by the fact that the average premium increase for the industry this year was just 4.84%, the lowest in 10 years. In contrast, the Commonwealth contribution to the State run public hospital system increased by 8.4% in real terms from 2014–15 to 2015–16.

While it is clear that private health is delivering strong health outcomes for Australian consumers there is growing concern around affordability and the participation in the medium to long term.

There is significant opportunity for reform within the private health system to address affordability and sustainability concerns. Members Health (formerly hirmaa) has provided detailed analysis on an array of important reforms across a number of recent submissions relating to affordability and value. Members Health is also actively working with the Government directly through the Private Health Insurance Ministerial Advisory Committee and other official forums.

As such, this submission is not intended to provide in depth analysis of existing and already well supported policy positions, but instead it aims to outline and summarise key high level priorities. These priority areas include

- raising the Medicare Levy Surcharge (MLS);
- stabilization of the Australian Government Rebate at 25%;
- addressing the growth of private patients in public hospitals;
- support trials between Private Health Insurers and Primary Health Networks;
- developing chronic disease registers;
- developing models for effective and efficient prostheses pricing; and
- Remove Fringe Benefit Tax (FBT) from private health insurance.

Together, these initiatives represent comprehensive reform in the same spirit as those undertaken by the Howard/ Costello Government from 1997-2000, which were the catalyst for much of the success of the private health insurance industry as we know it today.

Members Health strongly believes that meaningful reform can be achieved to improve the value of private health insurance, alleviate cost pressures on the Government, and improve health outcomes, and we are pleased to provide this pre-budget submission for the full consideration of the Australian Government.

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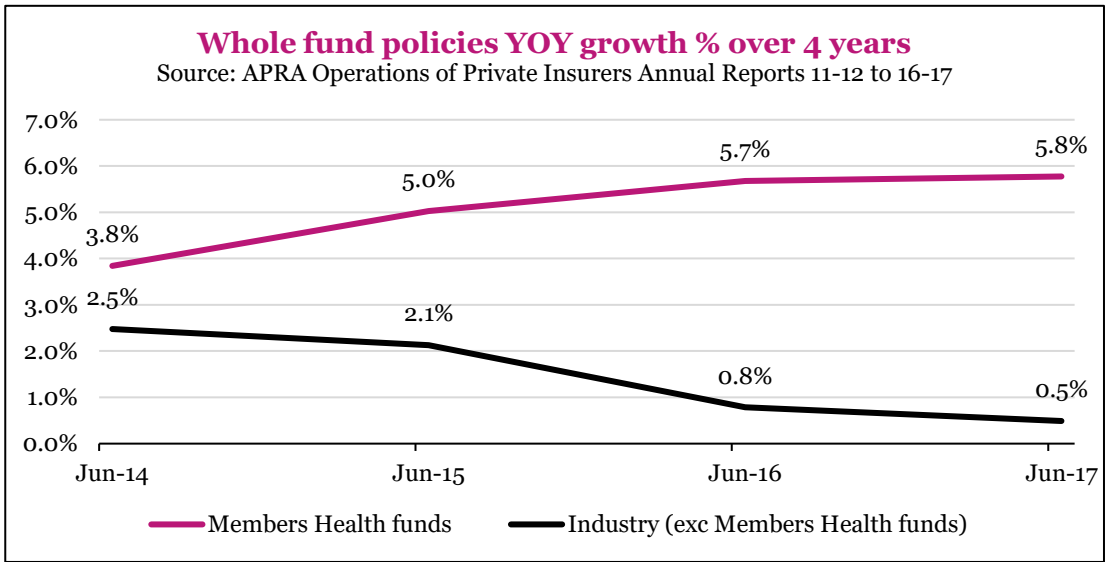
ABOUT MEMBERS HEALTH FUNDS

Members Health funds make up 24 of the 37 registered private health insurers and share one or more of the following attributes, being not-for-profit, member owned or community based. Combined, Members Health Funds provide health cover to over 1.7 million Australians nation-wide.

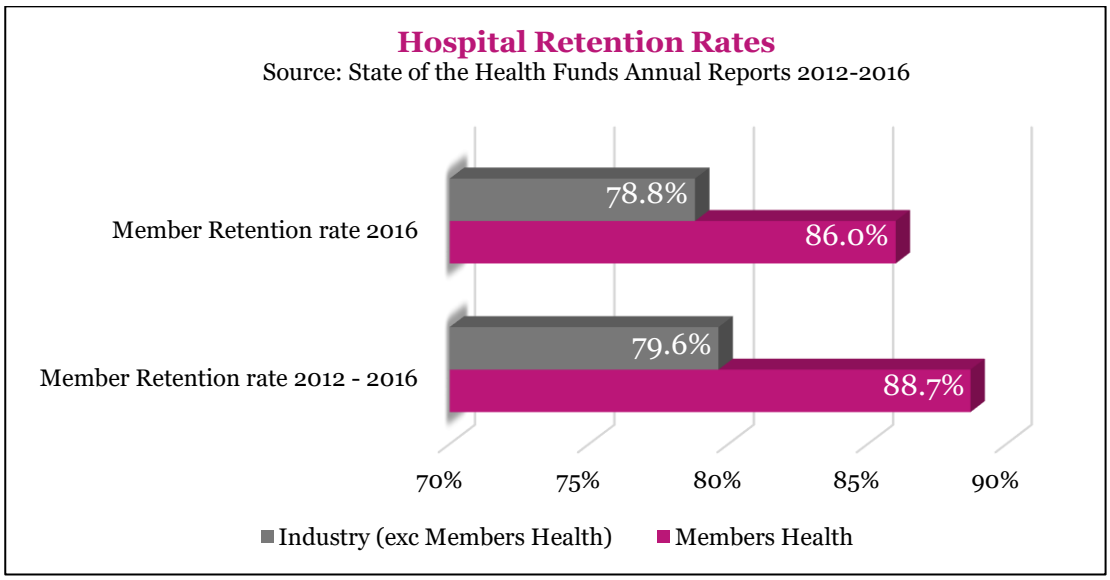
Members Health funds provide a highly valued service to key communities of interest spanning regional populations and industry groups, including military families, teachers, police, nurses and midwives, transport, mining and doctors. Regional communities in which Members Health insurers are headquartered include Townsville, Lithgow, Wollongong, Newcastle, Latrobe Valley, Launceston, Burnie and Mildura.

Data supplied by APRA, the Commonwealth Ombudsman and independently run surveys all consistently points to the Members Health funds as being the success story of the health insurance industry. On average they provide highly competitive policies with lower than average premium increases, offer excellent customer service, valued products and they are intimately connected to their communities of interest.

Members Health funds have consistently experienced average policyholder growth that is much faster than the rest of the industry. They also experience much higher policyholder retention rates. If it were not for the superior performance of the Members Health funds, participation in private health insurance would be much lower than it is today, highlighting the importance of the not-for-profit, member owned and community based health sector to the ongoing sustainability of private health insurance.

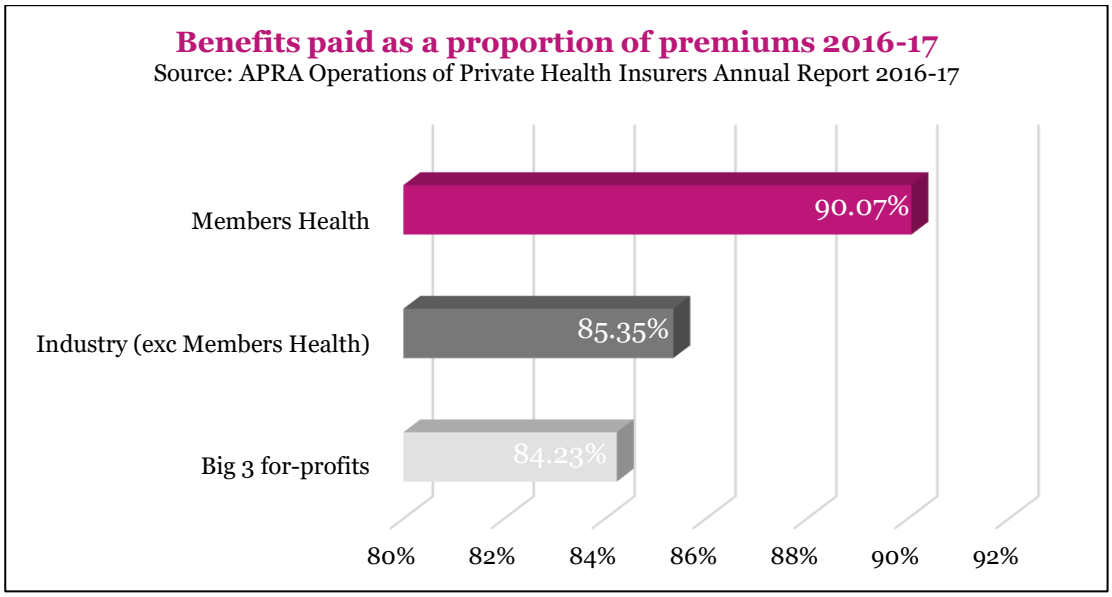


All Members Health funds operate on narrow margins. Notably, several Members Health funds operate on premiums that have a net negative margin in order to prioritise the needs of policy holders, and make small profits only after accounting for returns on investments.



Members Health funds are respected and valued by their members and ensure a diverse and highly competitive marketplace. Extremely high levels of customer satisfaction is reflected in official policyholder growth and member retention figures, which are well above the industry average.

The not-for-profit, member owned and community based business model ensures that the consumer is the primary focus of all Members Health funds. In 2016-17 Members Health funds re-invested over 90 per cent of all premiums paid, back to policyholders, as benefits. This is in contrast to the for-profit insurers, which operate primarily for the benefit of shareholders and return only around 85 per cent.



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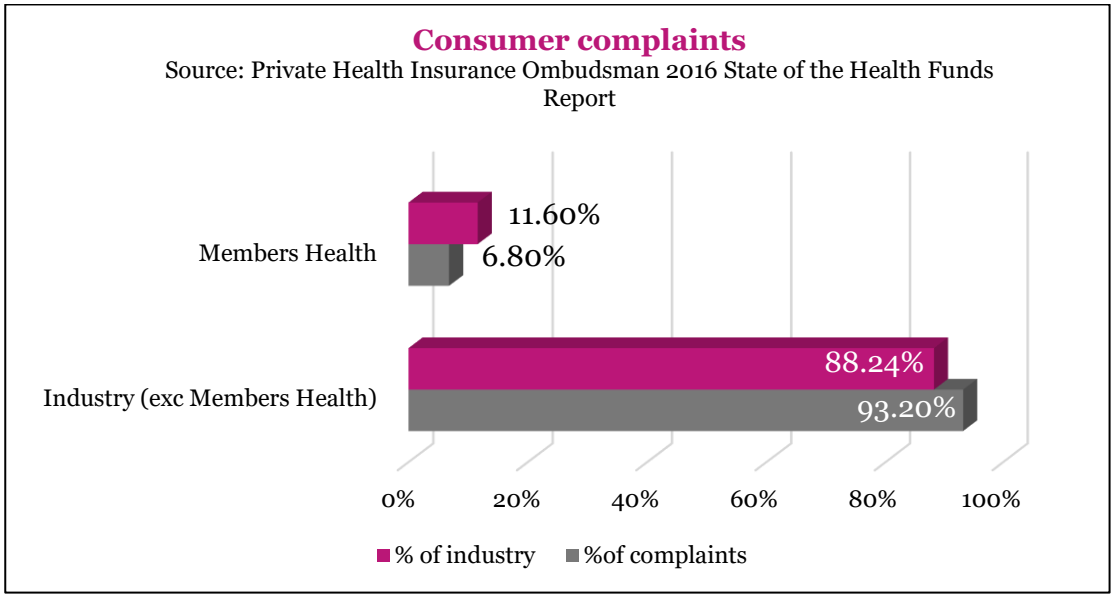
Each year Members Health facilitates an independent customer satisfaction survey of the policyholders of
participating Members Health funds. The survey has been conducted annually for the past 11 years by independent research group Discovery Research. In 2017, a very large sample of more than 15,100 policyholders provided responses to the survey. Overall, the customer satisfaction survey found:

- 97% of respondents were satisfied with their membership.
- 99% of respondents believe that their health fund has integrity.
- 99% of respondents believe that their fund delivered personal service.
- 98% supported the general proposition that their fund was a member-service focused company

Statistics from the Commonwealth Private Health Insurance Ombudsman's (PHIO) also reinforce the value proposition of the not-for-profit, member-owned and community based insurers, with Members Health insurers significantly underrepresented in the area of complaints.



Notably Members Health funds, comprise approximately 11.60% of the private health insurance industry yet attract far fewer complaints than their market share.

Without the superior performance, diversity and competition provided by Members Health funds, Australian consumers and the private health industry as a whole would be significantly worse off in terms of both participation levels, cost and the quality of private health insurance.

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The Medicare Levy Surcharge (MLS)

Budget proposal 1: Reduce the threshold tiers for the MLS and increase the MLS surcharge.

> *People on higher incomes should take greater individual responsibility for the cost of their health care. They are better placed to take out private health insurance and should be required to do so (Commission of Audit: 7.3 A pathway to reforming health care)*

The Medicare Levy Surcharge (MLS) is intended to encourage Australians with higher incomes to take out private health insurance. By encouraging more Australians to take out private health insurance the MLS relieves cost pressures on the public health system.

Presently the MLS threshold is $90,001 for singles and 180,001 for families. At this threshold point a levy of 1% is applicable, climbing to 1.5% for singles earning $140,001 or more and families earning $280,001 or more per annum (see table 1).

Table 1: MLS Income thresholds

Singles **Families**	**≤$90,000** **≤$180,000**	**$90,001-105,000** **$180,001-210,000**	**$105,001-140,000** **$210,001-280,000**	**≥$140,001** **≥$280,001**
Rebate				
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
< age 65	25.934%	17.289%	8.644%	0%
Age 65-69	30.256%	21.612%	12.966%	0%
Age 70+	34.579%	25.934%	17.289%	0%
Medicare Levy Surcharge				
All ages	0.0%	1.0%	1.25%	1.5%

Note: The family income threshold is increased by $1,500 for each Medicare levy surcharge dependent child after the first child.

In 2014-15 over 160,000 Australians paid the MLS. This represents a significant number of Australians whose incomes are above the existing threshold for the MLS.

To better encourage Australians with the financial capacity to contribute to take greater personal responsibility for their own healthcare needs, it is important that the MLS be increased. This will provide a greater incentive for the take-up of private health insurance. This proposal should not be regarded as a punitive measure but one that that promotes individual responsibility and frees up the public system for those who need it most.

This is critical given the continued growth in public hospital waiting lists for elective surgery with data from the AIHW showing the national medium waiting time for elective surgery increasing by more than a third since 2001-2002.

The 2014 Commission of Audit stated that "people on higher incomes should take greater individual responsibility for the cost of their health care. They are better placed to take out private health insurance and should be required to do so" and that "his requirement on higher income earners to take greater responsibility for their health care could be put into effect through a penalty arrangement that would result in an increase in the Medicare Levy surcharge for people on high incomes who do not purchase expanded private health insurance coverage".

The proposed levy surcharge of between 3% and 3.5% are appropriate and would effectively encourage higher income earners to adopt private health insurance, alleviating pressure on the public system and alleviating pressure on waiting lists for those Australians who need it most.

In addition to increasing the MLS the 2014 Commission of Audit recommended reducing the income levels at which the MLS tiers apply, beginning at $88,000 for singles for 'tier 1'. This figure is notably higher than the national average yearly wage[1] and would effectively serve to further encourage more Australians to adopt private health insurance for the benefit of those needing to use public systems.

This proposal has significant potential to assist the Government return to budget surplus. According to the Australian Tax Office, 164,535 Australians paid the Medicare Levy Surcharge in the 2014-15 income year. The Australian Institute for Health and Welfare has estimated per person expenditure on health averages $6,846.

For the approximately 164,535 Australians paying the MLS this represents an average total cost of over $1.1 Billion. Given that Government pays more than 90% of the cost of the cost of treatment at a public hospital, an increase in the MLS, incentivising greater take-up of private health insurance could potentially save the Government around $800 million per annum. This is compared to the approximately $218 million in tax revenue raised from the MLS in 2014-15. This initiative would also relieve pressure on public hospitals

Table 2: Proposed Medicate Levy Surcharge

	Base Tier	Tier 1	Tier 2	Tier 3
Singles	Less than $88,000	$88,000 - $102,000	$102,000 - $136,000	$136,000 +
Families	Less than $176,000	$176,000 - $204,000	$204,000 - $272,000	$272,000 +
Current	0.00%	1.00%	1.25%	1.50%
Proposed	**0.00%**	**3.00%**	**3.25%**	**3.50%**

Source: National Commission of Audit.

[1] http://www.abs.gov.au/ausstats/abs@.nsf/mf/6302.0?opendocument&ref=HPKI

In order to ensure that the MLS continues to encourage Australians able to better able to afford private health insurance it is also considered important that income tiers are frozen in order to ensure that Australians entering the tier 1 category for the first time actively consider private health insurance for the benefit of those less able to cater for their own healthcare needs.

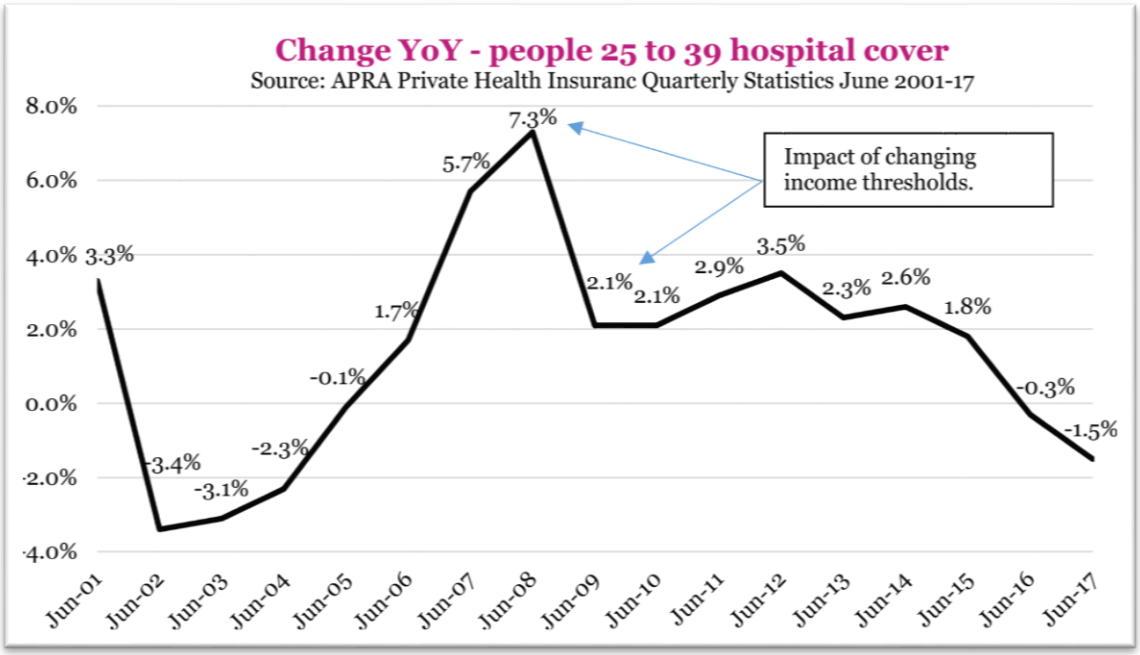
The success of lower tiers in generating membership to private health is well established. In 2006-07 the decision to increase the base tier from $50,000 for singles and $100,000 for families to $70,000 and $140,000 respectively resulted in a significant drop in private health insurance among young Australians.

Medicate Levy Surcharge 2006 - 2007

	Single	Family
No children	$50,000	$100,000
MLS	**1.0%**	**1.0%**

Medicate Levy Surcharge 2007 - 2008

	Single	Family
No children	$70,000	$140,000
MLS	**1.0%**	**1.0%**



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The Australian Government Private Health Insurance Rebate

Budget proposal 2: Stabilise the value of the Australian Government Private Health Insurance Rebate at no less than 25%

With the introduction of Medicare from 1 February 1984, the publically-funded health insurance scheme quickly became the major funder of the Australian health system. This resulted in a significant decline in private hospital insurance membership until 1999, when private health insurance (PHI) coverage reached an historic low of 30.5%[2].

The Government at the time, led by Prime Minister John Howard and Treasurer Peter Costello, saw the need to arrest this trend given the significant transfer of cost pressures to the public sector as a result of less people choosing to obtain private health insurance.

The solution was a multi-pronged approach that included the:

1. Introduction of the Medicare Levy Surcharge in 1997, set at 1% of taxable income, to penalise higher-income earners who choose not to take out private hospital cover.
2. Introduction of the Government rebate on private health insurance (the rebate) in 1999, set at 30% of the cost of a policy (and the introduction of higher rebates for older Australians in 2005).
3. Introduction of Lifetime Health Cover (LHC) loadings in 2000 to incentivise the early take-up of private hospital cover

As demonstrated by the timeline below (Figure 1), these policies in combination, were highly effective in rebalancing the private and public health insurance systems, with private health insurance membership now exceeding 50% of the population.

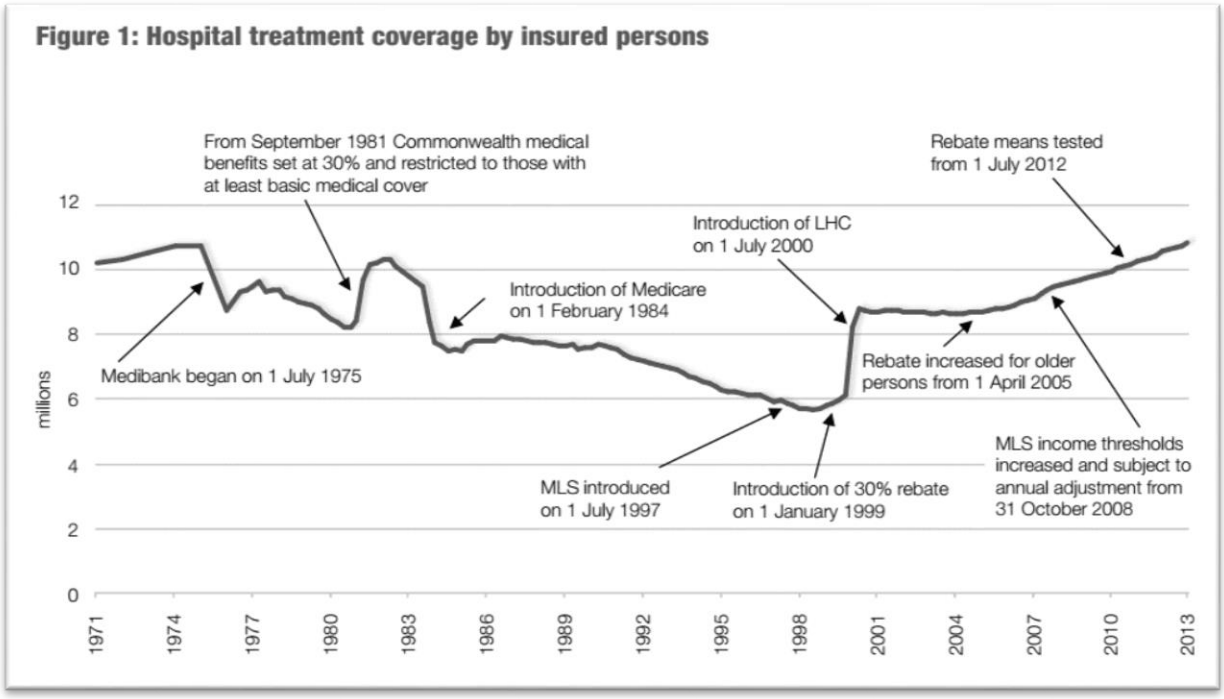
As a result of the significant increase in the proportion of the Australian population with private health insurance the Australian Government Private Health Insurance Rebate, valued at around $6.1 Billion per annum, leveraged $20 Billion in medical benefits from private health insurers in 2016-17, around $11.7 Billion more in real terms than in 1999.

In more recent years the universality of the rebate has been reduced by a number of policy changes that has seen the value of the rebate decline significantly. These changes included:

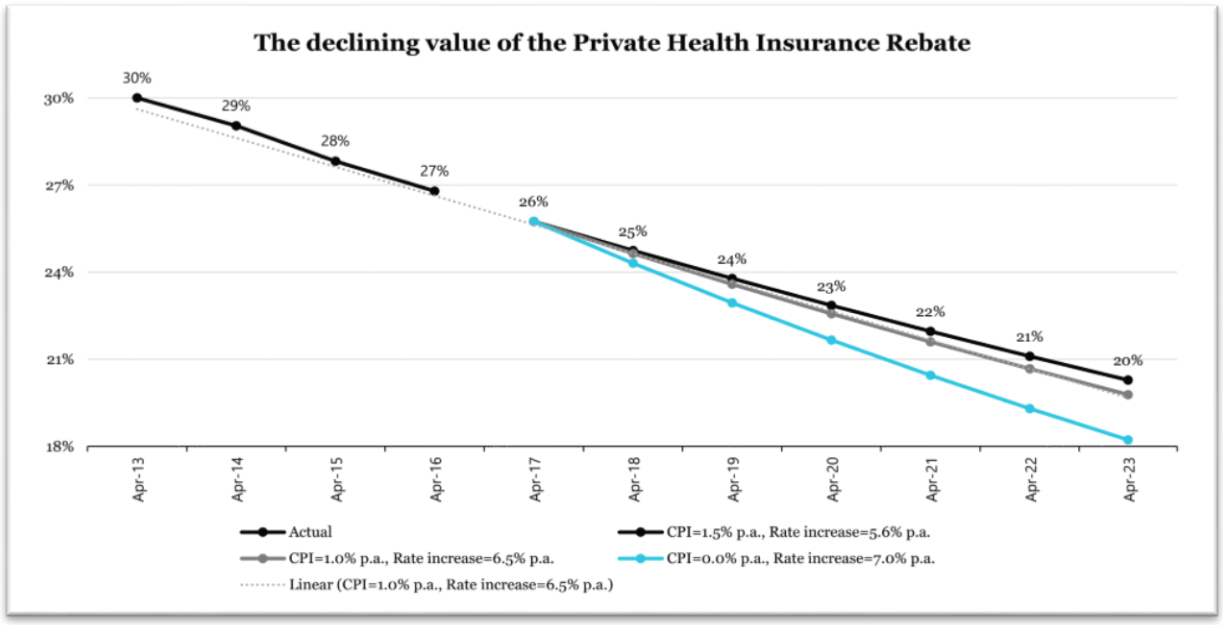
- Indexing of the rebate to the lesser of CPI or the actual increase in commercial premiums.
- Means testing of the rebate on private health insurance.
- Removing the rebate from the lifetime health cover loading portion of premium.

In particular, the decision to index the rebate to the lesser of CPI or the actual increase in premiums has seen the steady decline in the value of the private health insurance rebate by around 1% every year. At current rates this decline will see the value of the rebate fall below 20% in just three years.

[2] Derived from *Operations of the Private Health Insurers annual report data*; 1998-99, PHIAC



Source: Private Health Insurance Administration Council 2013



Source: DBN Actuaries

At a time when Australians are struggling with a range of cost of living pressures, the continued decline in the value of the Australian Government Rebate is causing real affordability concerns.

The increasing cost pressures associated with private health is demonstrated by the fact that since December 2016 there has been a decline in the percentage of Australians with private health insurance. This represents the first such decline in approximately 15 years.

Of particular concern is the fact that the declining Australian Government Rebate is making health insurance less affordable and more difficult to access for younger Australians.

In July of this year Morgan Stanley released a report titled 'Australia Healthcare and Insurance: Point Break' in which the authors observed that declining growth in private health take up had put the system "past the tipping point". This was based on a significant fall in private health insurance holders under 60 years of age since 2014 and projects a trend of further declining participation in coming years.

Younger Australians in particular are experiencing considerable cost pressures across a number of areas including housing affordability, university debts and low wages growth to name just a few. Subsequently, given the current economic environment, younger Australians are increasingly finding health insurance unaffordable and the declining Australian Government Rebate is only acting to further exacerbate those affordability pressures. Furthermore, because Australian Government Rebate is means tested, it only goes to those on lower incomes who most need it.

The base tier value of the rebate effective from 1 April 2017 to 31 March 2018 is now just 25.934%, a far cry from the original 30%.

Table 1: MLS Income thresholds

Singles **Families**	**≤$90,000** **≤$180,000**	**$90,001-105,000** **$180,001-210,000**	**$105,001-140,000** **$210,001-280,000**	**≥$140,001** **≥$280,001**
Rebate				
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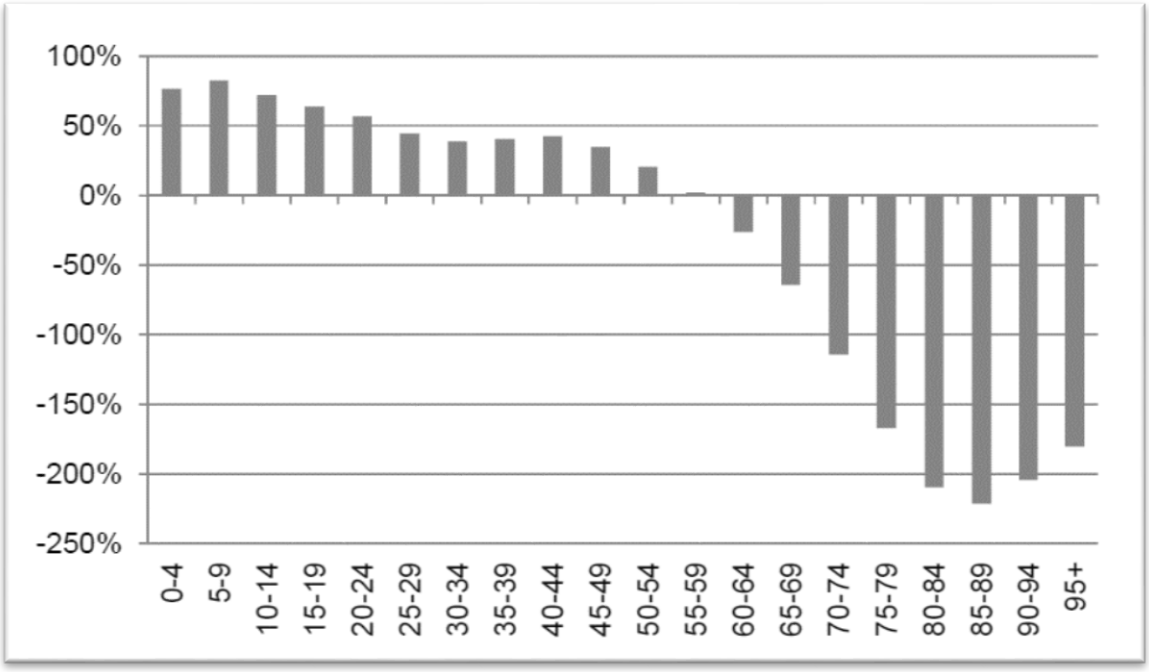
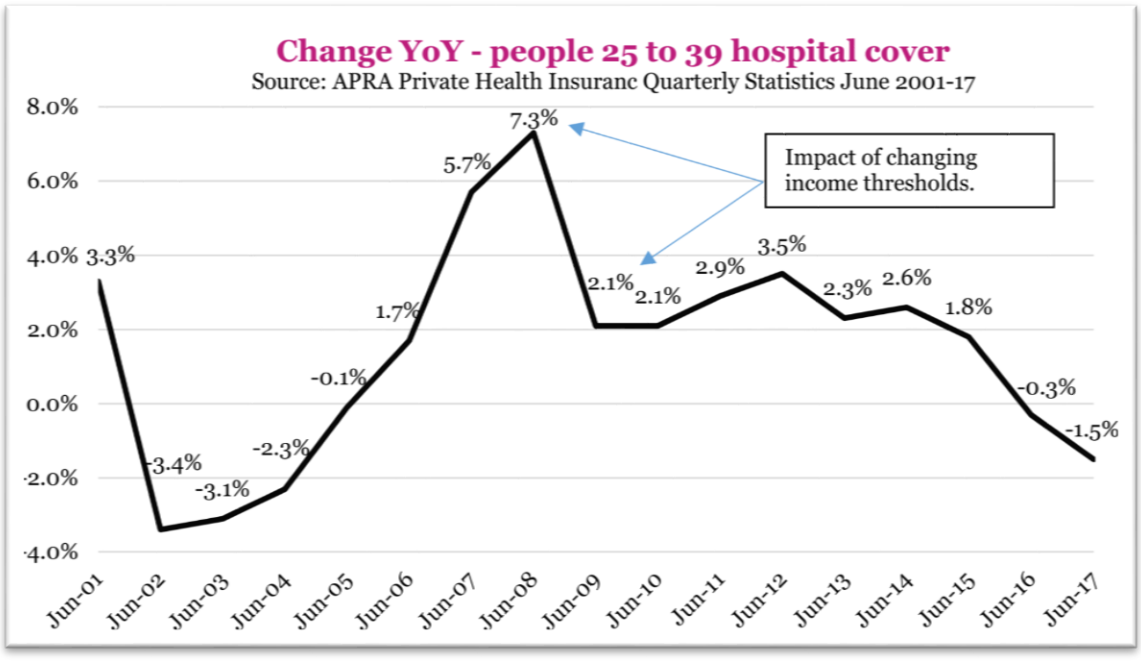
Medicare Levy Surcharge				
All ages	0.0%	1.0%	1.25%	1.5%

The risk of losing younger people from the private health insurance pool is a significant threat to the sustainability of private health system. Private health insurance operates under a system of Community Rating in which younger, healthier members cross subsidize older members who are likely to more frequently claim benefits.

Cross subsidization of policy holders (5 year average)



Source: APRA (prepared by Goldman Sachs)



Source: APRA

If younger people continue to leave the system, private health insurance will become more expensive, thus exacerbating affordability further and potentially driving even more people out. This potential death spiral will drive many people into the public health system and onto already overstretched public hospital waiting lists.

The Australian Government Private Health Insurance Rebate is a fundamental pillar to the sustainability of the private health system in Australia. It is the only one of the three pillars which helps Australians access cover through assistance, and is paid directly to the consumer.

Given that the rebate will soon dive under 25% for the first time, we are entering unchartered territory and there are real risks that unless there is decisive action by Government to stabilise the value of the Australian Government Rebate by placing a floor under it, of not less than 25%, private health insurance participation will continue to decline to the significant detriment of the public system and all Australia's health consumers.

Addressing the growth Private Patients in Public Hospitals

Budget proposal 3: Limit private health insurance benefits to the medical costs of private treatment in public hospital

Between 2002 and 2016 benefit growth in public hospitals increased from $295.6 million to $1,062 billion, this represents an average cost to the average private health insurance hospital policy of around $150 and a total cost of to the Commonwealth Government of around $2 billion.

This represents around 14% of patients accessing the public health system in a system in which the national medium waiting time for elective surgery has increased by more than a third since 2001-2002.

This growth is being actively driven by public hospital administrations seeking to cost shift public services to private health insurance policy holders and the Commonwealth Government. They are also driven by deliberate policy settings established by State and Territory Governments, especially though the setting of targets for 'own source' revenue which several jurisdictions have adopted.

In August 2017 the Minister for Health released an Options Paper (the Options Paper) on reform in this area entitled "Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals".

The Options Paper articulated a number of policy reform proposals with Members Health clearly supporting a prefered policy option in a response dated 15 September 2017. This proposal called for the limiting of private health insurance benefits to the medical costs of private treatment in public hospitals.

This option would address the use of as accomodation and other non-medical costs as enticements, which represent over 70% of the average benefit used in a public hospital setting.

Of those genuine medical procedures and items for which private health insurance will remain applicable, transparency should ensure that the price efficiency is prioritised. For example, prostheses should be charged at the lower public hospital rate as opposed to the higher prostheses list price.

By limiting the use of benefits to the medical costs of private treatment within a public hospital setting, and by ensuring that hospital administrators or State and Territory jurisdictions do not replace existing revenue streams at the expense of patients.

As such, this policy proposal would achieve a significant reduction in the number of patients utilising their private health insurance in public hospitals, while ensuring that private patients choosing to access public hospitals fully retain their ability to choose their preferred doctor or medical specialist.

Improving Primary Care and Chronic Disease Management

Budget proposal 4: Support trials between Private Health Insurers and Primary Health Networks

Figures from the Australian Institute of Health and Welfare show that in 2015–16 there were almost 680,000 potentially preventable hospitalisations (6% of all hospital admissions) and almost 2.7 million potentially preventable hospitalisation bed days (9% of all hospital bed days).

It is in the interest of both private health insurers and Governments to ensure that Australians have access to high quality primary health care.

Chronic Disease Management (GP services) on the Medicare Benefits Schedule (MBS) enable GPs to plan and coordinate the health care of patients with chronic or terminal medical conditions, including patients with these conditions who require multidisciplinary, team-based care from a GP and at least two other health or care providers. At present eligibility for CDM services is a clinical judgement for the GP, taking into account the patient's medical condition and care needs, as well as the general guidance set out in the MBS.

Unless specifically exempted, under the Private Health Insurance (Health Insurance Business) Rules insurers are unable to pay benefits for out of hospital services where there is a Medicare benefit payable. It is important to note that Members Health supports Medicare, and supports Medicare continuing to cover out-of-hospital medical practitioner services. However, we do not think, this should preclude insurers from playing a complimentary role, if it is in the interests of the patient.

Members Health does not support managed care, which has proven to be a failure in the United States of America, however we do believe that stronger patient outcomes can be achieved by the creation of closer relationships between General Practitioners and insurers in the area of primary health. As a simple first step, Members Health proposes that insurers and General Practitioners be supported to trial coordinated approaches to better leverage the existing Broader Health Cover (BHC) programs offered by insurers.

At present, General Practitioners are most often unaware of the insurance status of their patient and of the range of BHC programs offered by their patient's insurer. Better information sharing

between insurers, patients and General Practitioners about insurance status and about programs available would allow earlier and more targeted use of these programs, with the full knowledge and support of the General Practitioners. Members Health suggests that Government works to facilitate and support initiatives and/or trials in this space, including engagement of the Primary Health Networks.

Members Health also believes that insurers can contribute positively to the success of the My Health Record and that their involvement will improve health outcomes across the population – the over-arching goal of a national e-health strategy.

Where consent is given by the consumer, private health insurers should be allowed access to individuals My Health Record. This will improve insurers' capacity to assist and support policyholders through preventative health programs, enhance consumer choice and empowerment and recognises the role that health insurers play in supporting healthcare delivery.

Budget proposal 5: Develop national Chronic Disease Registries

Chronic conditions remain the predominant cause of illness, premature mortality and health system utilisation in Australia. To put into context the cost of chronic disease, cardiovascular diseases, oral health, mental illness and musculoskeletal conditions incurred a direct health care costs of $27 billion in 2008–2009 (36 per cent of allocated health expenditure).

In the 12 months to 31 March 2017, $47 million was spent by private health insurers on Chronic Disease Management Programs as private health insurers, along with Government, are the only sections of the health industry for which there is a financial incentive to prevent illness and to expedite recovery.

The exploration and development of innovative approaches to improve the overall health of Australians through preventative health measures, as well as improved treatment and care strategies are essential if long term health costs are to be reduced for health payers such as patients, Government and private health insurers. Most importantly, improvements in these areas benefit all Australians through improved quality of life.

The identification of what works and what does not work in primary care, as well as the rapid distribution of research, data and information to partner entities is critical to the development and improvement of innovative health solutions in preventative health and health management.

The establishment of chronic disease registries could be developed through this process. Members Health views the development of disease registries as vital to achieve long term savings in the health system through the improvement of community health. Properly developed, these registries would be key resources for research, data and evaluating management practices.

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Registries would also serve as an information source for researchers, health professionals and health partners as they develop preventative and management models for chronic conditions.

Supporting a forward thinking, fair and sustainable prostheses market

Budget proposal 7: Fund the development of prostheses pricing models and trials

The effective and equitable reform of the prostheses benefits setting system is long overdue and, while important Government initiatives have achieved noteworthy savings to key prostheses via agreements with the Medical Technology Association of Australia (MTAA) up to 2022, there is an urgent need for prioritisation of resources for the development of a sustainable model for prostheses benefits in the longer term.

Members Health congratulates the Minister for Health for leading reform which saw the largest savings to prostheses devices in many years. These savings will be $188 million in the first year equating to around $34 a year for every policy. However, there is still around $800 million in additional savings which we believe can be made by achieving a parity in the price of prostheses devices in private and public hospital settings. If private health consumers were able to access prostheses devices in private settings at the same cost as prostheses in public hospital settings premiums could be reduced by around $130 per hospital policy.

Members Health believes that comprehensive, meaningful and sustainable reform of the prostheses benefits-setting system needs to reflect the foundation principles of the successful Pharmaceutical Benefits Scheme (PBS) which has proven highly effective at analysing supply chains and reducing the cost pharmaceutical products to Australian patients, specifically, the prostheses benefits-setting system should incorporate:

- Mandatory Price Disclosure (Legislated)
- Value based pricing (Legislated)
- High quality economic analysis

Resources should also be provided to develop a National Prostheses Purchasing Authority. At present, several state jurisdictions operate central procurement agencies/ authorities which exist to maximise price advantages derived from the bulk acquisition of commonly used prostheses.

For example, in Victoria, Health Purchasing Victoria (HPV) is responsible for managing contracts totaling $776.9 million on behalf of 27 participating health services. HPV's purpose is to improve the collective purchasing power of Victorian public health services and hospitals through achieving 'best value' outcomes in the procurement of health-related goods, services and equipment across 48 contract categories.

There is an opportunity to utilise such an entity on a national scale to drive even greater savings in the prostheses and medical devices market by combining the market power of both Public and Private Hospitals.

Such a national entity would incorporate best practice standards, and could be established and supported by a
federation model of health jurisdictions or centrally by the Commonwealth Government.

Given the anticipated volume of devices purchased by a national authority, covering public and private sectors, it would be reasonable to assume a significant reduction in prices across both sectors. Additionally, the present administrative burden of both private and public hospitals would be reduced substantively.

The work of a National Prostheses Purchasing Authority should also adopt a reference pricing mechanism to facilitate international benchmarking. Both the development of a National Prostheses Purchasing Authority and the establishment of a reference pricing system will require upfront investment prior to delivering significant system wide savings.

Encourage younger membership through salary sacrificing

Budget proposal 7: Remove Fringe Benefit Tax from Private Health Insurance

The Fringe Benefits Tax Assessment Act (FBTAA) provides for a wide range of exemptions that have been introduced by the Government either on social, political or administrative convenience grounds.

Members Health strongly believes that those benefits afforded to the public by private health insurance, namely the significant alleviation of pressure on the public health system, is such as to warrant the exemption of private health insurance from the Fringe Benefit Tax (FBT). Specifically, the payment of an employee's PHI premiums by their employer (or associate or third party by arrangement) should be exempted.

The adoption of 'salary sacrificing' for private health insurance would also draw younger people to private health insurance which would serve to alleviate cost pressures associated with an aging private health insurance membership.

Further, such a policy action will serve as a notable workforce productivity measure with private health members able to access much faster elective surgery than those seeking to access the public system. This is particularly important given that around 311,000 Australians were forced to wait more than 37 days and nearly 15,000 forced to wait more than a year for elective surgery in public hospital settings in 2015-16.